

Web only Annex 3:

Development of the complex intervention:

Previous work has explored barriers and facilitators of chlamydia testing within the Theory of Planned Behaviour (TPB) model^{4,6} Staff in practices with higher testing rates have a more positive attitude to testing and are more aware of its benefits than those with lower testing rates, but all staff felt uncomfortable discussing chlamydia screening outside a sexual health consultation and few considered that testing men was important.⁶ Subjective norms played an important role; staff in higher screening practices had normalised screening and it had a higher profile in the practice, with more staff involved and reminders through computer prompts which are simple and easy to set up, or discussions at practice meetings. Staff from practices with lower testing rates, reported that usually only a single member of staff was championing chlamydia testing with little support from the rest of the practice staff or feedback from National Chlamydia Screening Programme (NCSP) coordinators. All practices reported it would be easier to offer screening if it had a higher profile throughout the practice using posters and leaflets and media messages.⁶ Finally, personal beliefs in behavioural control were pivotal to successful screening; staff needed to know how to raise screening with patients, which tests to use with easy accessibility to them and to believe they had the time to do this.⁶ Patients' personal attitudes and beliefs mentioned above also influence whether they accept screening and need to be addressed in any intervention.¹⁶ Behavioural control beliefs again played an important part, with women stressing that tests should be free, quick and easily accessible in different settings and offered confidentially without any stigma attached to a diagnosis.¹⁶

After careful consideration of our own qualitative findings at national professional meetings, consultation with the NCSP nationally and locally, and discussion with the trial steering group that included a general practitioner (GP), a patient and an NCSP representative, we

developed a complex intervention (Box) which was discussed with general practice staff in the feasibility phase of the trial. Ethics No Ref:08/H1211/57. We conducted 12 short semi-structured face-to-face interviews with five GPs, three nurses, a practice manager and three receptionists to ascertain if the components of our intervention were practical, how they could be implemented into their daily work pattern, and how they could be improved.¹⁷ During this phase the feasibility of fitting the intervention into the NCSP was also discussed with the NCSP national steering group and NCSP leads within the South West.

Feedback from staff indicated that raising the importance of screening and giving them the skills and confidence to offer screening tests through the workshop and maintaining chlamydia as a priority through on-going support were important. All staff valued the posters and patient invitation cards and thought that the computer prompts would help to remind clinicians to test and maintain awareness. A new barrier to testing identified in the GP staff interviews was lack of ownership in the practice with regard to chlamydia screening tests. Staff reported that testing targets were for the NCSP coordinator to meet rather than the practices. Therefore, to promote ownership of testing, we designed posters based on the 2009 NHS "Sex Worth talking about" sexual health campaign with the text "WE are a chlamydia screening practice". Furthermore, in the intervention the staff delivering the intervention emphasised that the targets were the practices' and were related to them in terms of the numbers of their patients eligible for testing and the number needed to test each week to hit the target.